



DEPARTMENT OF FINANCE AND ADMINISTRATION
Office of Personnel Management
Request for Family and Medical Leave

Agency/Institution Name			Date (MM/DD/YY)	
Employee Name (Last, First, Middle)			BEGIN FMLA: (MM/DD/YY)	
Personnel Number	Business Area	Personnel Area	END FMLA: (MM/DD/YY)	
Organization Unit	Job Title		Phone	
<p>Check all that apply:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I am requesting Family and Medical Leave (FMLA) for the days shown above.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I understand that FMLA, as federally mandated, is unpaid leave. Current state policy however requires substitution of accrued paid leave for FMLA time requested..</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I understand that the Personnel Department may require a written second opinion from a health care provider at the expense of the state.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I understand, if approved, that during FMLA, the agency/institution will continue paying the Employer portion of my group Health Plan, if I am a participant. I understand that I am responsible for paying the Employee's portion for the Health Plan for each pay Period. If I do not pay, my Health Plan may be cancelled after 30 days.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No The Employee Benefits Division may contact my Health Care Provider for clarification/authenticity of my medical certification if required.</p>				
Employee Signature			Date (MM/DD/YY)	

AUTHORIZATION:

<input type="checkbox"/> Approved <input type="checkbox"/> No Disapproved <input type="checkbox"/> Approved <input type="checkbox"/> No Disapproved	Approving Authority	Date (MM/DD/YY)
	Approving Authority	Date (MM/DD/YY)
	Data Entered By	Date (MM/DD/YY)